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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation
Against:

Case No. 800-2017-030578

David H. Betat, M.D.
2255 Cedar Hill Way
Lakeport, CA 95453

FIRST AMENDED ACCUSATION

Physician's and Surgeon's Certificate No. G 57755,
Respondent.

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California.
2. On or about July 14, 1986, the Medical Board issued Physician's and Surgeon's Certificate Number G 57755 to David H. Betat, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2020, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

1 4. Section 2227 of the Code provides that a licensee who is found guilty under the
2 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
3 one year, placed on probation and required to pay the costs of probation monitoring, or such other
4 action taken in relation to discipline as the Board deems proper.

5 5. Section 2234 of the Code, in pertinent part, states:

6 “The board shall take action against any licensee who is charged with unprofessional
7 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not
8 limited to, the following:

9 “(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
10 violation of, or conspiring to violate any provision of this chapter.

11 “(b) Gross negligence.

12 “(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
13 omissions. An initial negligent act or omission followed by a separate and distinct departure from
14 the applicable standard of care shall constitute repeated negligent acts.

15 “(1) An initial negligent diagnosis followed by an act or omission medically appropriate for
16 that negligent diagnosis of the patient shall constitute a single negligent act.

17 “(2) When the standard of care requires a change in the diagnosis, act, or omission that
18 constitutes the negligent act described in paragraph (1), including, but not limited to, a
19 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the
20 applicable standard of care, each departure constitutes a separate and distinct breach of the
21 standard of care.”

22 6. Section 725, in pertinent part, states:

23 “(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or
24 administering of drugs or treatment . . . as determined by the standard of the community of
25 licensees is unprofessional conduct for a physician and surgeon . . .”

26 7. Section 2266 of the Code states:

27 “The failure of a physician and surgeon to maintain adequate and accurate records relating
28 to the provision of services to their patients constitutes unprofessional conduct.”

1 FIRST CAUSE FOR DISCIPLINE

2 **(Gross Negligence/Repeated Negligent Acts/Excessive Prescribing)**

3 8. Respondent David H. Betat, M.D. is subject to disciplinary action under section 2234
4 and/or 2234(b) and/or 2234(c) and/or 725 in that Respondent was grossly negligent and/or
5 committed repeated acts of negligence and/or prescribed excessively. The circumstances are as
6 follows:

7 Patient 1¹

8 9. In 2009, Patient 1, a 31-year old male roofer, came under Respondent's care and
9 treatment for chronic low back pain. Respondent prescribed methadone, 10 mg, #120.² In his
10 interview with the Board's investigator, Respondent stated that the patient had been started on
11 methadone by a prior physician "for at least a year." Respondent also diagnosed the patient with
12 depression, for which he prescribed Cymbalta, 60 mg.³ In 2010, Respondent added lorazepam⁴ to
13 the patient's medications.

14 10. Respondent's records for Patient 1 are brief, routinely lack significant discussion of
15 the patient's complaints, his response to treatment or the rationale for prescribing. Depo-
16 testosterone, 200 mg, 1 ml, as an example, was presumably prescribed for opiate-induced
17 hypogonadism, but Respondent's records do not discuss either the medical indication or the
18 patient's response. Similarly, diazepam⁵, 10 mg, #30, was prescribed in May 2013, without any
19 discussion of the medical indication for its use or the rationale for adding another benzodiazepine
20 to the patient's existing regimen of opiates and benzodiazepines. In his interview with the Board's

21
22 ¹ Patients' names are redacted to protect privacy.

23 ² Methadone hydrochloride is a controlled substance and an opioid indicated for the
24 treatment of pain severe enough to require around-the-clock long-term opioid management and
25 for which alternative treatments have failed. Methadone exposes users to the risks of opioid
26 addiction, misuse and abuse, which can lead to overdose and death.

27 ³ Cymbalta is a trade name for duloxetine, a selective serotonin and norepinephrine
28 reuptake inhibitor used for treating depression, anxiety disorder and pain.

⁴ Lorazepam, which is marketed under the trade name Ativan, is a controlled substance
and a benzodiazepine used to treat anxiety, among other conditions. Benzodiazepines, when taken
in conjunction with opiates, increase the risk of respiratory arrest.

⁵ Diazepam, which is marketed under the trade name Valium, is a controlled substance
and benzodiazepine used to treat anxiety. When taken in conjunction with opiates, it can increase
the risk of respiratory arrest.

investigator, Respondent stated that he discussed the risks with Patient 1 and warned him not to take lorazepam and diazepam together, but this is not documented in his records.

11. Patient 1 developed tolerance to methadone and his dosage increased to as much as 120 mg/day, which he then sought to taper. As of October, 2013, the patient's medications included methadone, 10 mg, #120, diazepam, 10 mg, #60, lorazepam, 1 mg, #60 and hydrocodone⁶, 10/325 mg, #60.

12. On October 5, 2013, Patient 1 died. The Coroner listed "Polypharmacy (diazepam, methadone, hydrocodone)" as the probable cause of death.

Patient 2

13. In and before 2015, and continuing through June 2017, Patient 2, a 46-year old male with a history significant for multiple abdominal surgeries and chronic pain, was under Respondent's care for chronic pain management. During this time, Respondent prescribed methadone, 10 mg, and oxycodone⁷, 30mg, for long-acting and short-acting pain relief. Although the plan documented in Respondent's records was for 300 tablets/month methadone and 120 tablets of oxycontin, Respondent regularly prescribed far in excess of the planned amount of methadone such that, between 2015 and 2017, the patient would receive from 500 to more than 1,000 tablets in a month. Moreover, the amount prescribed did not correlate to the patient's documented pain complaints, with some additional prescriptions being written at times that the patient reported feeling better. Although Respondent's records stated that the patient "admitted to taking extreme amounts of methadone per day," it was stated that the patient's finances would not permit a change of opiate medication. Respondent also noted that the patient was utilizing multiple pharmacies to obtain additional amounts of opiates and, although at one point in time Respondent restricted the patient to a single pharmacy, Respondent continued to prescribe the

⁶ Hydrocodone bitartrate and acetaminophen, also marketed under the trade name Norco, is a controlled substance and a short-acting opiate medication. When taken in combination with a long-acting opiate, such as methadone, and benzodiazepines, hydrocodone increases the risk of respiratory arrest.

⁷ Oxycodone is a narcotic analgesic with multiple actions similar to those of morphine. Oxycodone is a controlled substance and is available in combination with other drugs or alone. It can produce drug dependence and therefore has the potential for being abused.

1 opiate medication in high doses. It was only when Respondent closed his private practice that
2 Patient 2 was referred to a pain specialist for management of his chronic pain.

3 Patient 3

4 14. In and before 2015, and continuing through June 2017, Patient 3, a 51-year old
5 female, was under Respondent's care and treatment for myofascial pain syndrome and mild
6 degenerative arthritis. Respondent prescribed oxycodone/acetaminophen, 10/325 mg, #120, and
7 hydrocodone bitartrate/acetaminophen, 10/325 mg, #120, for management of Patient 3's chronic
8 pain. Beginning in or about April 2016, Respondent added Baclofen⁸, 10 mg, #120, to the
9 patient's medication regimen. Respondent did not chart the medical indication or rationale for
10 utilizing a combination of two short-acting opiates and a muscle relaxant, nor did he document his
11 discussion of the risks of this drug combination with the patient.

12 Patient 4

13 15. Patient 4, a 54-year old male with a history significant for Bipolar Disorder, chronic
14 pain treated with high dose opiates and chronic obstructive pulmonary disease (COPD).
15 Beginning in or about January 2015, Patient 4 complained of feeling tired and his mother, who
16 accompanied him to his appointment on January 20, 2015, reported that he looked yellow to her.
17 No additional history regarding the patient's fatigue or the mother's report of a jaundiced
18 appearance was recorded and the objective findings in the record for the visit were identical to
19 three previous visits, which suggests that the findings were simply carried forward from prior
20 visits. Although the patient had chronic COPD and recurrent pneumonia, his lungs were reported
21 to be clear, with no rales or wheezes, as had been the finding on every prior visit. Respondent did
22 not order any lab tests or otherwise assess the new complaint of fatigue. On June 8, 2015, Patient
23 4 reported left lateral pain over the upper abdomen and ribs. Respondent noted tenderness to the
24 area, but did not further describe or investigate the new complaint. On July 6, Patient 4 returned,
25 complaining of left sharp pain, which was made worse with taking deep breaths. The patient was

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27 ⁸ Baclofen is a muscle relaxant that may potentially have adverse reactions, including
28 drowsiness. When Baclofen is taken in combination with opiate medications, the risk of
respiratory depression and hypotension is increased.

1 noted to be very drowsy and he reported that he had been unable to sleep at night. The objective
2 finding from the prior visit was carried forward in the note of the visit, but no further description
3 was stated and no diagnostic or lab tests were ordered. The patient's lungs were again reported to
4 be clear. Respondent discharged the patient from his care for illicit drug use.

5 16. On July 13, 2015, Patient 4 was seen in the local emergency room with complaints of
6 shortness of breath over the previous 8 or 9 days. A chest x-ray showed a patchy consolidation in
7 the right upper lobe. A CT scan identified a number of lesions in the lung and in the liver. Lab
8 studies showed significant elevated alkaline phosphatase (382), elevated AST (115), anemia,
9 elevated bilirubin (1.3) and abnormal creatinine (1.20). Patient 4 was diagnosed with metastatic
10 cancer and died on July 25, 2015.

11 Patient 5

12 17. Patient 5, a 70-year old man with COPD had been prescribed morphine sulfate⁹ as
13 well as other opiates and sedative hypnotics for an extended period. In 2013, Patient 5 was
14 receiving prescriptions from another physician until March, when Respondent recommenced
15 prescribing to him. On March 19, 2013, Respondent noted that the patient "feels tired a lot. feels
16 week. overmedicated by opiates?" Nevertheless, Respondent prescribed a full month supply of the
17 patient's opiate medications. On April 17, 2013, Respondent carried forward the patient's past
18 complaints of fatigue, as well as the possibility that the patient was overmedicated; however,
19 Respondent did not alter his prescribing. Patient 5 died on April 21, 2013, of cardiorespiratory
20 arrest.

21 18. On March 19, 2013, when Patient 5's wife raised the concern that he was
22 overmedicated, Respondent obtained and recorded an abnormal oxygen saturation level of 87%.
23 He also noted "crackles" in the right lower base of the lungs. Respondent did not record the
24 patient's respiratory rate. Despite these abnormal findings, Patient 5's COPD was stated to be

25
26 ⁹ Morphine sulfate is a controlled substance and a potent opioid intended for the
27 management of pain severe enough to require daily, around-the-clock, long-term opioid
28 management and for which alternative treatment options are inadequate. Morphine sulfate tablets
expose patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead
to overdose and death.

1 stable. On April 17, 2013, abnormal findings in the lung continued, as did the patient's
2 complaints of fatigue. Neither an oxygen saturation level nor a respiratory rate was obtained.
3 Although the patient was hypertensive with a blood pressure of 152/98, the assessment stated that
4 he was "normotensive, in no acute distress."

5 Patient 6

6 19. Patient 6, a 77-year old female, was admitted to a nursing home for which
7 Respondent was the Medical Director on November 16, 2016. Patient 6 had a history significant
8 for atrial fibrillation, hypertension, diabetes, end-stage renal disease on hemodialysis, DNR status
9 and recent wheelchair-bound status. On November 18, 2016, Respondent evaluated the patient.
10 Although she was receiving pain medication, hydrocodone, 5 mg, Respondent did not perform
11 and/or did not document an assessment of the patient's pain, its etiology, frequency or severity.
12 No treatment plan for the patient's pain was documented in the chart. On December 5, 2016,
13 Respondent documented that the patient had developed bed sores and that she was noncompliant
14 with directions to turn in bed to relieve pressure; however, there is no documented examination of
15 the sores, nor a treatment plan other than to continue recommendations for patient compliance.
16 The patient's pain increased about that time and Respondent increased the dosage of her opioid
17 medications, but did not document an assessment and plan for her condition. On December 23,
18 2016, Respondent documented a face-to-face encounter with the patient, but the note omits a
19 chief complaint and vital signs and lacks a physical examination of the patient's skin or
20 assessment of her pain. Respondent did order a wound assessment, which was performed by a
21 consultant and revealed large bilateral buttock pressure sores with necrotic skin. Respondent
22 continued to increase the patient's pain medication, adding morphine sulfate, 15 mg, extended
23 release tablets on January 3, 2017, but he did not reassess her condition. The patient's daughter
24 complained that her mother was over sedated and the medication was changed to a short-acting
25 opioid, but without a documented evaluation. The patient's bed sores worsened and she was
26 transferred to another facility, where she expired from sepsis on January 15, 2017.

1 Patients 1 through 6

2 20. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject
3 to disciplinary action based on his gross negligence, repeated negligent acts and/or excessive
4 prescribing as set forth above and including, but not limited to, the following:

- 5 A. Respondent prescribed excessively and/or inappropriately to Patients 1 through 6;
6 B. Respondent failed to follow up appropriately on acute changes in Patients 4, 5 and 6.

7 **SECOND CAUSE FOR DISCIPLINE**

8 **(Failure to Maintain Adequate and Accurate Records)**

9 21. Complainant incorporates the allegations of the First Cause for Discipline as though
10 fully set out here. Respondent is guilty of unprofessional conduct and Respondent's certificate is
11 subject to disciplinary action for violation of Section 2266 of the Code for failure to keep
12 adequate and accurate medical records, including but not limited to the following deficiencies.

13 22. In addition to the patients described in the First Cause for Discipline, complainant
14 alleges that Patient 7, a former landscaper, was under Respondent's care for chronic pain
15 management. As with the other patients, Respondent's records for Patient 6 are inaccurate and/or
16 omit important information about the patient's vital signs or how abnormal findings were
17 managed. As with the other patients, high blood pressure readings were described as
18 "normotensive" on some occasions, while no reading was obtained on other occasions, yet the
19 patient was still described as normotensive.

20 23. Respondent's records regularly lacked a description of the condition in question as
21 well as supportive facts, such as palliative or provocative factors, quality, quantity, region,
22 radiation, severity at timing.

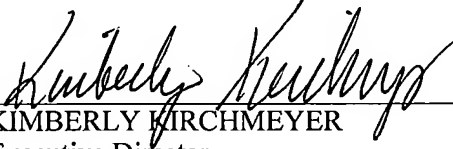
23 24. Respondent's records regularly stated that a medication had been prescribed or
24 refilled for the patient, but did not state the medical indication or rationale for the prescription or
25 refill.

26 **PRAYER**

27 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
28 and that following the hearing, the Board issue a decision:

- 1 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 57755,
- 2 issued to David H. Betat, M.D.;
- 3 2. Revoking, suspending or denying approval of David H. Betat, M.D.'s authority to
- 4 supervise physician assistants and advanced practice nurses;
- 5 3. Ordering David H. Betat, M.D., if placed on probation, to pay the Board the costs of
- 6 probation monitoring; and
- 7 4. Taking such other and further action as deemed necessary and proper.

8
9 DATED: May 13, 2019


KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
State of California
Complainant

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